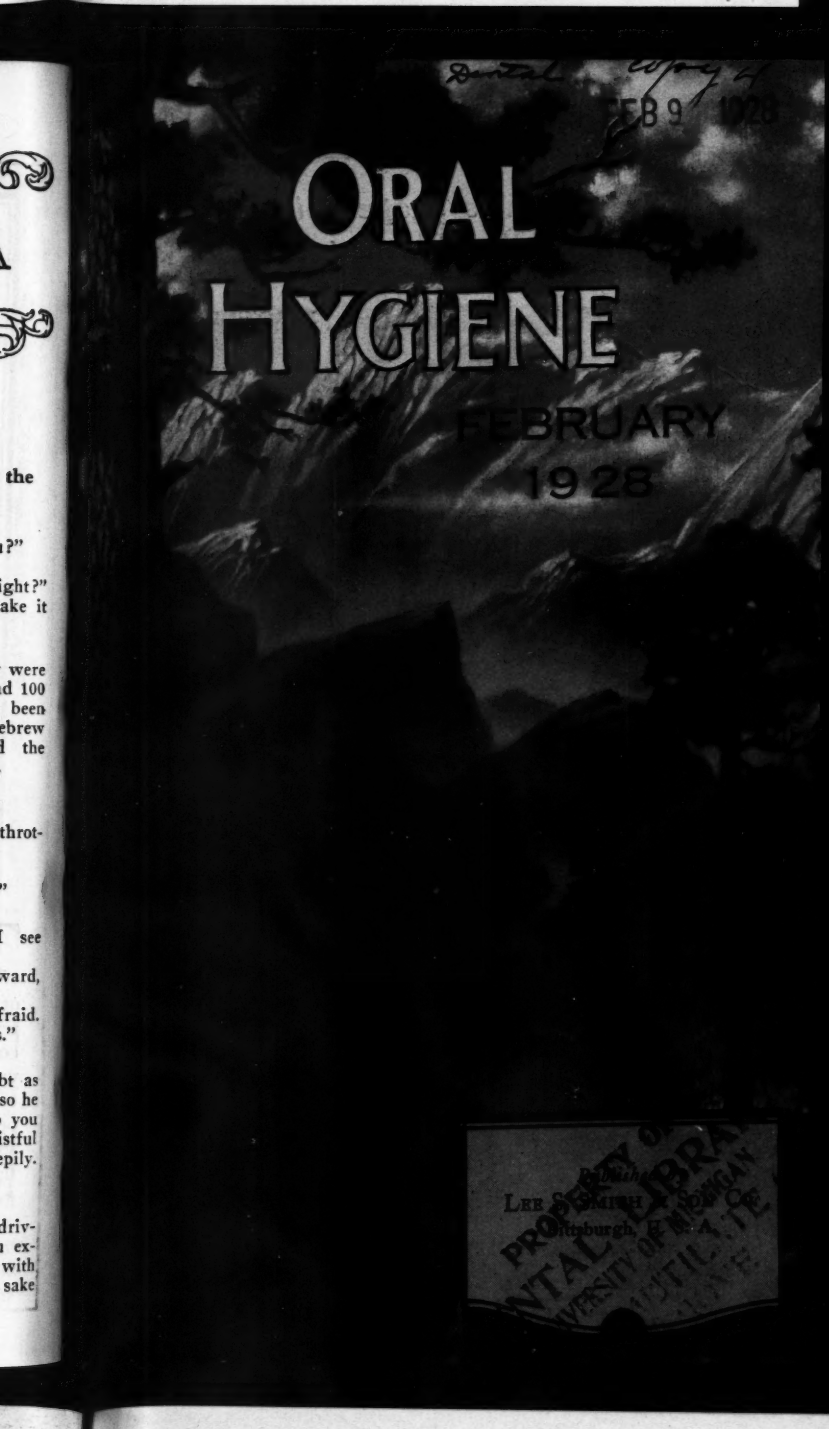
ORAL
HYGIENE
FEBRUARY
1928

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February 1928

ORAL HYGIENE

Registered in U.S. Patent Office — Registered Trade Mark, Great Britain

Founded 1911

FEBRUARY 1928 — VOLUME 18 NUMBER 2

GETTING A CHILD TO SCHOOL ON TIME IN THE MORNING

Courtesy of Judge—

MAKING MONE

By D. D. RIDER, D.D.S., Minneapolis, Minn

PURSUANT to the many comments upon it, and requests for more articles similar to it and detailed information upon matters contained in the article on "How Operative Prophylaxis Builds a Practice," in the September, 1927, issue of ORAL HYGIENE, and in order to relieve the burden of the extensive correspondence which has resulted from the publication of that article, I carry on with a sincere hope that I might possibly be of help to others of "that 75 per cent who need more business." I am not sufficiently bigoted to think that I can help all dentists. I am satisfied that I have solved for myself and have assisted some few dentists in solving some of the economic conditions that seem to harass the majority of dentists, and out of my experience could and would be glad to submit tried, proven, and result-producing methods whereby the elusive public can be educated in the value of the proper care of the teeth. Education carried on to such a point that the prospective patient actually gets into some dental office, sold and ready to do business. "For health's sake it's the dental service the public needs and not a correspondence course in dental education."

No big moral issue has ever been accomplished until it was approached from an economic standpoint. The brewers laughed and continued to exploit society until prohibition was approached from an economic standpoint. Dentists will continue to exploit and not educate the public until a dental health educational campaign is also approached from an economic standpoint.

The solution for an educational campaign lies within that 75 per cent who need more business and who are willing to serve at a reasonable and equitable fee that big and much abused middle class. The pseudo-highbrows who enjoy a lucrative practice and the ethical quacks who mount ill-fitting restorations upon putrescent roots will continue to spend their time and attention in exploiting the public and not in educating them. The job of public education should be done; and if the A.D.A. or some other organization is not going to put on an educational campaign and be of service to the vast majority of its members, *then let them not growl* like the dog in the manger because "oral hygiene propaganda has been seized upon as a sales stimulant by commercial interests in marketing dentifrices that claim to be everything from prophylactics to panaceas for every dental ill." (Editorial in *The Den-*

—*and* FRIENDS

Dr. Rider's September article stirred readers, many of whom sought further information about "Operative Prophylaxis." The present article deals with the subject in its relation to dental economics and lay education.

tal Cosmos, January, 1927).

If we all are going to do just what we want to do, who is going to do that which ought to be done? Getting dentists together into a concerted action even though it be to their financial gain, is not only hard—it is almost impossible.

It is one of the purposes of this article to show the individual dentist, who might be interested, that he can help himself, irrespective of what the other fellow thinks, says, or does, and at the same time can do his part in doing that which the profession as a whole has so shamefully neglected to do.

There has been and still is an inexcusable and uneconomical absence of a dental business course in our universities. Men are thrown out into the world to practice a profession under economic conditions concerning which they have little or no knowledge after being taught to approach any discussion on dental business (Sh!) trembling with fear and the danger of excommunication from our "humanity loving society." Due to the lack of business courses in our universities and a fear of the other fellow's *misinterpretation* (please note *mis*) of an ethical code, altogether too many dentists are being kept from rendering more of a much needed service to humanity and are stealing from those dependent upon them the benefits of that which they have a right to expect from a possible earning capacity. Is it not high time that our schools wake up to the fact that if they really want dentists to help serve the public they must first have peace of mind financially, and contentment in the pursuit of their affairs? You say some schools recently have called in successful men to lecture to the undergraduates on dental economics. Yes, but who have they had? If all are like the ones that I know, they are intolerant, bigoted, egotistical, bombastic individuals who advance theories entirely unsuited to meet the economic conditions under which the vast majority of their hearers will be compelled to operate.

Let *me* hear from the fellows who have started with nothing and without the good fortune of getting into the well-to-do-class, have made a professional and financial success, and who with sincerity and sympathy *tell me how it is done.* I do not want to hear from the fellows who have but five cents, and ignoring the human side of the dental business, if you please, tell me how to make a million, and who, in estimating the patient's ability to pay, totally and knowingly do not take into consideration quality of service. There is no objection to the men getting a higher fee who render a higher type of dental service. The sad fact remains that there is altogether too much evidence that superior service does not always accompany the superior fee. Such exploitation is damnable and inhuman commercialism under a professional cloak.

Therefore, let it be taught, among other things, that the vast majority of dentists will make more money by keeping busy and working for a reasonable, economic, and equitable fee, and furthermore will be of greater service to humanity. Also, do not neglect to teach them how to get more business and how to handle it after they have it. You show me a dentist who has built up a successful practise solely and only because he is a "good dentist" and I'll not only prove that you are mistaken but will also show you fifty or more who are equally good if not better and who are working far below capacity.

A man came into my office recently and volunteered the information that business was going to be better, that at the University of Minnesota they now have a five-year dental course, and that classes have gradually diminished in numbers until now there are but a comparatively few freshmen taking dentistry. This condition was going to make a shortage of dentists; and thus, I presume according to the law of supply and demand, those of us who were already out would get more business and better fees.

Due to the fact that the large majority of those dentists who do go to dental business meetings take very little or no active interest in the proceedings beyond voting yes or no, even though they may have been repeatedly urged to do so, one thing is sure: that the only ones left to put across this idea of longer dental courses are professors and members of the A.D.A. who are not affected by or who are totally indifferent to the economic conditions under which the vast majority of dentists are compelled to operate.

According to statistics in 1921, "1432 dentists were admitted to practice while during that same period of time 1900 ceased to practice."

On top of this, in the same editorial that was quoted earlier we read, "As the result of this activity in spreading before the

public mind the importance of the care of the teeth and attention to their welfare as a factor of health, there has grown up a greatly increased demand for dental treatment, an important phase of which is at present inadequately met. We refer particularly to the class of wage-earners and those of limited income who quite as definitely as those of the poorer classes are unable to pay the usual fees for dental service and are therefore compelled from force of economic circumstances to suffer the pains and penalties of dental neglect. The fees for dental service have automatically increased in proportion to the demand for that service. The dentist tends to eliminate from his clientele the least remunerative cases as the demands for his services multiply. This is perhaps a legitimate expression of the instinct of self-preservation, yet when persistently followed without exception to its extreme manifestation is not without the taint of commercialism. The result of the foregoing tendency is to put dental service beyond the reach of what may be found to be a majority of the wage-earning public and make it a luxury only within the compass of the well-to-do. Viewed as a humanitarian public health measure, such a position is more than regrettable, it borders on the calamitous.

"The members of the dental profession created the situation that we have here endeavored to outline, and for that reason we are impelled to ask, what, in a broad practical way, will they do about it?"

Now then coupled with the fact that some of the best men we now have are three-year course men is another situation. You could not make real dentists out of some fellows if you kept them in school twenty years, and after graduating and passing the state board, and keeping up his annual state board donation to politics, such a dentist, without conscience, virtually has life immunity and license in spite of our ethical code, to do a *job* in dentistry calculated only as an excuse to extract that amount of money which he feels his patient is able to pay.

Furthermore, in accepting the recognized true economic basis of arriving at a proper fee for dentistry, the result is that dental fees will have to be necessarily higher according to the length of time for preparation. *If this is not following out a policy of the public be damned* —then you name it.

Now then under such economic conditions, let me ask, what is going to be the use of educating the public in the value of the care of the teeth and holding the price of dental service beyond their reach? Do *you* call this professionalism or commercialism?

In my previous article on "How Operative Prophylaxis Builds a Practice" I endeavored to show how a dentist can *legitimately* increase his income by

selling the patient, who has already come into his office, the maximum amount of needed dental service. As mutually beneficial as this is in its relation to an actual patient, the dentist who stops here is much like some fellows who spend time and money in taking postgraduate courses and have very few patients on whom to practice their newly acquired technique. I also emphasized the need for an ethical and flexible lay educational campaign. I dropped the suggestion that through the practical application of what I have called Operative Prophylaxis I have been able to make absolute strangers into prospective patients, make prospective patients into potential patients, make potential patients into actual patients, and through actual patients have increased my referred business. If I have done this alone without any organization back of me, what could you do if you had the right kind of an organization behind you?

So that I shall not be misunderstood, let me state that I have all praise and thanks for all the efforts of and the benefits derived from the organization of which I am a member. As an organization to promote technical skill and high ideals and looking after our political situation and making an honest effort to serve the poor the A.D.A. is a huge success. However, if as much time and attention had been spent in devising means of educating the public as has been spent in furnishing means for exploiting the public, both the dentists and the public would be far better off. What do I mean by exploiting? I mean that any mechanical dental work that is done *without* taking the pationt's future health into consideration, *and only then,* as a necessary, unavoidable, and unfortunate means of putting the entire mouth in a healthy condition, to be *followed by an honest and intelligent prophylactic service* — is exploitation, and the rankest kind of commercialism.

The vast majority of dentists whom I have personally endeavored to assist by going into detail with them and showing them how to contract dental work with their own patients in their own offices, were trying to sell people something they do not want—dental restorations, the preparations for which are more or less painful, and which always "cost too much." Furthermore they were trying to do all this in competition with a well established desire for cars, fur coats, hooch, cosmetics, permanent waves, and most anything else you care to add to the list. How about *you?*

If an individual dentist or an organization is going to influence strangers and prospective patients to become potential and actual patients, they must know how to sell their patients dental service. The fellow who looks into his patient's mouth and locates places where he can

put in bridges, crowns, and fillings, and gives an estimate of cost, is pricing mechanical dental work only. He is asking that patient to bet, we will say, $150 of the patient's money as against the dentist's time, overhead, cost of production, and the dentist's appraisal of the "patient's ability to pay," that he (the dentist) knows how to do and will do good mechanical dental work. *What can such a patient say about such a dentist that he can't say about any other dentist in town?* From *his* (the patient's) standpoint of absolute knowledge, *positively nothing.* How does the patient know but that he will be up against the same thing, or worse, within the next year or so? *He does not.* He has made this bet before and lost. He knows that he can't tell by the price a dentist charges what kind of dental work he is going to get. You tell him of the wonderful service you give your patients in calling them up or otherwise notifying them to come in for periodic examinations. Yes—examinations for what? *More dental work!* He knows that too, and that is the reason he does not come in later for your service.

Now then, let us look at this from the standpoint of the practical application of Operative Prophylaxis. Upon approaching the chair and going through the usual formalities, I make a hurried survey of the general condition of the teeth and investing tissues. Moving away from the chair and in front of the patient, I immediately proceed to sell that patient on the idea of *Prophylactic Dental Health Service,* before even going into detailed examination, taking x-rays, or impressions for study casts. Those of you who read my previous article in the September issue of ORAL HYGIENE, can very well visualize and understand how I proceed to do this.

When the dentists are willing to assume a reasonable amount of responsibility for the dental work done and are willing to co-operate with the patient thereafter in an honest effort to prevent future trouble and can convince their patients that they are capable of rendering such service, then Mr. Mid L. Class is perfectly willing to pay a reasonable and equitable fee to have necessary dental work performed and furthermore automatically becomes your enthusiastic booster. And why? Because he not only is enthusiastic about that kind of service, but he *has* something to say about *you* that he can't say about the ethical quack who needs to be either smoked out or change his ways.

You can *keep* the ethical quack in the A.D.A. if you wish and I'll raise no objection, but he is *not* the caliber we want in an honest-to-God dental health educational campaign.

Let me now enumerate, without discussion, some of the economic conditions that are familiar to so many of us and ask you to draw upon your experience

and imagination in seeing how the practical application of Operative Prophylaxis might be of service.

1. Are you ever troubled with collections?

2. Do you have difficulty in getting patients to come in for periodic examination after restorative and curative treatment is finished?

3. Have you ever wondered why loyal patients are not better boosters, and how you could stimulate them into activity?

4. Have you ever had to compete with a reputable shyster or ethical quack who apparently has success (?) while you —you finish it.

5. Have you ever had a good prospect, a potential patient, leave your office without appointment and wish you could get her back?

6. Have you ever met a regular fellow who, upon being introduced and told that you were a dentist, said that he and his family needed dental work done and asked for your card but who never came to your office?

7. Have you ever wanted to increase your income by working at capacity?

8. Knowing that there was an unlimited amount of needed dental service, have you ever wondered how you could get yours?

9. How many of your prospective patients come into your office sold and ready to do business?

10. Did it ever occur to you that a real, ethical and result-producing Dental Health Educational Campaign would be of *mutual* benefit to all parties concerned and needs no apology?

The master key to open a Dental Health Educational Campaign either by the individual dentist or an organization is *Prophylaxis*. Almost inexhaustible are the talking points. The proper dentists to put on such a campaign are those who practice what I have called Operative Prophylaxis, even though they have done it under a different name, or no name at all. What's in a name? It's the result that counts. Such men are selling something that people *do* want and are interested in and *so can you* if you put it to them in the proper manner. Don't tell *me* that people will not go through the expense, pain, and inconvenience of having necessary dental work done to arrive at a point where their dental troubles are practically at an end. I have proved this too often not to know. This puts no small amount of the responsibility upon the dentist. And why not? That's where it belongs.

What is the use of interpolating in technical papers and talking about our love for and responsibility to dear humanity and then do nothing? What is the value in writing flowery exhortations on dental health subjects back and forth to each other in professional magazines whose reading matter never reaches the public whom it concerns?

We, as an association and individually, have passed the buck of public education to philanthropists, school boards, health agencies, municipalities, states, dental supply houses, dental supply manufacturers and laboratories, etc., and hide behind our professional cloak and expect the other fellow to do our job, while we indulge in "watchful waiting" for *more business.*

Feeling that you will get dentists' hearty co-operation only after you have shown them the economic value of the same, and that you must tolerate and grant them compensation for their efforts, would it not be better for us to join and without exploitation spread the gospel of oral hygiene and in so doing discharge our professional responsibility to society?

If the A.D.A. or any other honest organization will submit a practical dental health educational campaign better than the one which I have tentatively drawn up for my own satisfaction and guidance, I will be one of the first to volunteer my services, and I'll *not* waste time in debating any infinitesimal detail of modus operandi, nor indulge in asinine professional jealousy nor be a party to any double-crossing political intrigue that might in any way whatsoever defeat the accomplishment of the big dental health educational job *that should be done.*

The Dental Society of the State of New York

Editor ORAL HYGIENE:

I have been wondering if you would make a special appeal through the medium of your journal to the Chairmen of the Legislative Committees in the various states throughout the Union to read the article by W. I. Jones, D.D.S., of Columbus, Ohio, in your October (1927) issue, entitled "Unreasonable Discrimination in Whiskey Withdrawals," and request that their views be forwarded to the Chairman of the Legislative Committee of American Dental Association at large, in order that some action may be taken in the matter in a systematic way.

I am heartily in accord with Dr. Jones' views, and wish to take the initiative in attempting to do all in my power to aid in the correction of such improper discrimination against the members of our profession.

Very truly yours,

N. J. PATTERSON, D.D.S.
Chairman of the Legislative Committee
of the State of New York.

Try MODEL MAKIN

By S. L. KALINOWS

AFTER a long, tiresome and nervous day at the chair, dear brother, what do you do for relief? If nothing, you are wasting your artistic and mechanical abilities on the easy-chair. Dr. A. Snyder told you that you are an artist and a sculptor,* and I will add that you are also a mechanic by training. Dream out your plans in the easy-chair and materialize them in the cellar workshop.

Model making is my hobby and it all came through my wife's desire for a ship model. The idea of making a ship model struck me so suddenly that I could not resist the temptation to make one. Gathering up all available scraps of wood, cloth, twine, etc., the task of ship building was launched, and after five weeks of spare time work an imitation of a Dutch ship took its form.

Next the aviation fever came on and when "Lindy" crossed the deep blue domain of Father Neptune, a model of his monoplane was in the making. Next two weeks completed that task, and the mail plane was in the making. Byrd's three-motor Fokker plane came as a matter of course, and now I can safely say that my hobby has paid me well for the time spent on it. Two of the planes are in my office, and when children come in for treatments, their interest in the planes overcomes their fear of the chair. As these models are not mere toys, but built to scale and precision, many of my older patients take interest in them, and many a bad toothache is overcome temporarily by curiosity and inquisitiveness. These air steeds are certainly great psychological tools, even if they do not fly.

In making models two things are very necessary. First you must visualize the production of your effort, that is you must see the model completed before you start making it, then plan the actual construction, step by step. This will help the dentist in planning the construction of his difficult dental cases at the chair. Second, once you start do not get discouraged because of difficulties encountered. This will teach you to be more patient with tedious and difficult operations at the chair. Do not loose any sleep or time at model building, but always remember that it is only a spare time hobby, and not the means of providing bread and butter for your family. Plenty of soap and water will wash your hands

*ORAL HYGIENE, Sept., 1927, p. 1740.

r a HOBBY

D.S., Pittsburgh, Pa.

A Dutch ship was my first effort in model making.

This model of the Spirit of St. Louis in my office has helped child patients to lose their fear of the chair.

clean and the careful use of tools will prevent any damage to them.

Much could be said about this hobby, but time and space will not permit. Look the pictures over, perhaps they will kindle your desire to make things with your hands. You will profit by doing so.

COMING

More articles in this series on Dentists' Hobbies.

Local Anesthesia—ts

By EDWARD REIT D.S.,

WHEN we pass a needle into the dense gums, as many men do, we immediately destroy delicate tissue cells directly in the path of the needle. The amount of tissue injured and the degree of post-operative pain depend upon the number of needle punctures we have made and the amount of tissue we have penetrated with our needle. By increasing the needle punctures we increase the injury to the tissues and there will be a corresponding increase in the degree of post-operative pain. Six or eight needle punctures will cause more of an injury than one such puncture. By starting our injection near the gingival margin or as Dr. Frawley suggests, by starting halfway between the gingival margin and then by gradually working or forcing the needle toward the apex, we penetrate dense vital tissues unnecessarily and further increase our injury.

The accumulation of dead or injured cells, resulting from the trauma of the needle, becomes a foreign substance and acts as an irritant. And the inflammatory process, which I have tried to show is so important and which is always present whenever the tissues are subjected to the action of an irritant, is hindered in its efforts to rid the dense gums of this irritant because the anesthetic solution contains an agent which has partially arrested the circulation to the part into which it was injected.

Local anesthetic substances acting upon living tissues, in which the vitality is artificially interfered with, and the circulation is disturbed cause a much more intense local poisoning and a much more intense local pain, than in tissues with undisturbed active metabolism and normal circulation.

So when a patient tells you of having had a tooth removed under a general anesthetic and that he has had no post-operative pain, it is because the dense gum structures surrounding that tooth have not been injured by needle punctures; their vitality has not been artificially interfered with; and their blood supply has in no way been disturbed.

The same happy result can be obtained under a local anesthetic providing we do not force our novocaine into the dense gum tissues. You know from experience that you can block off the lingual or inferior dental nerve and produce a profound anesthesia to the tooth upon which you propose to operate without having to flood the dense structures surrounding that tooth. Why not apply the same methods to the teeth of the superior maxilla?

The teeth of the superior maxilla, the buccal and labial

ts Uses and Abuses Part II

D.S., Cleveland, Ohio

alveolar process, the periosteum, the gums, and the mucous fold, all receive their nerve supply from branches given off the second division of the fifth nerve. After the nerve emerges from, or makes its exit through the foramen rotundum it traverses the spheno-palatine or pterygo palatine fossa and enters the floor of the orbit where it becomes the infra-orbital nerve. At a point approximately 5mm distal to the posterior floor of the orbit the second division gives off the posterior superior dental nerve. The course of this nerve is downward, forward, and laterally, and it enters the posterior superior dental foramen upon the posterior lateral tuberosity of the superior maxillary bone at a point approximately 2cm above the disto-gingival margin of the upper third molar. After it enters the superior maxillary bone it passes anteriorly into the middle plate of bone comprising the alveolar process.

The middle superior alveolar nerve arises from the infraorbital nerve within the infraorbital canal, and it courses downward laterally and slightly forward, being located in the outer wall of the maxillary sinus.

The anterior superior alveolar nerve arises from the infraorbital nerve at a point approximately 5mm distal to the opening of the infraorbital foramen. It passes downward and forward within the anterior wall of the antrum until it reaches an area above the apices of the central, lateral, and cuspid teeth.

After these three branches, the posterior, middle, and superior alveolar nerves, reach the region of the alveolar process above the apices of the teeth they anastomose freely with each other and form what is known as the superior dental plexus or outer nerve loop. This extremely complex nervous arrangement is situated above the apices of the teeth, and in bicuspid and molar region between the apices of the teeth and the floor of the antrum.

It is at this point we must deposit the anesthetic solution if we hope to get a profound anesthesia to the teeth and their surrounding structures.

Have you ever had an experience such as this? After flooding the soft structures with the anesthetic you attempt to prepare a sensitive cavity or even extract the tooth and find that the patient still complains of pain. The prevention of pain is a moral obligation you owe to your patients so you stop your operation and inject more fluid. After waiting the customary period you test out your area with a sharp instrument and find the soft tissues thoroughly anesthe-

tized. You proceed with your operation a second time and find much to your dismay that your patient still complains of pain. This time however, you complete your cavity preparation, or extract your tooth in spite of the pain; and many of us conclude that the patient was a neurotic and that the pain was more imaginary than real.

We err when we hastily jump to such conclusions. We can inject into the dense gums and anesthetise that tissue without getting a complete anesthesia to the tooth we propose to operate upon. In most cases the dental plexus above the apices of the teeth gives off two separate and distant branches. The first set is known as the superior dental rami and they pass to the apices of the roots and supply the teeth with sensation. The second set is the superior gingival rami, which enter the superior alveolar septa and supply the buccal gum tissue, periosteum, mucous membrane, and maxillary sinus.

If you deposit your solution at a point above the apices of the teeth, where the outer nerve loop or superior dental plexus is formed, you block all sensation to the teeth and surrounding soft structures.

Having decided upon where the novocaine should be deposited, your next problem then is to administer the anesthetic in such a manner as to eliminate the pain produced by the needle puncture. There is nothing a patient dreads more than the pain produced by the needle in making the various injections.

I have told you that many men inject into the dense fibrous gums surrounding a tooth. We cannot insert a needle into these tissues without injury, and furthermore it is exceedingly difficult to pass a needle into these structures without inflicting some pain upon the patient. The degree of pain varies, of course, with the size or rather thickness of the needle employed, the site of insertion and the gentleness of the operator.

All types of needles, ranging from a quarter inch to two inches in length, and from a twenty-five gauge to a nineteen gauge in thickness, are employed for the administration of local anesthetics. The operator who employs a heavy gauge needle will inflict more pain than the man who uses a thinner gauge needle.

Dr. Kells tells us that if we force a twenty-four-gauge needle into the dense gums our patient immediately questions our idea as to what constitutes painless dentistry, for such a procedure is decidedly painful as a rule.

If the puncture produced by a twenty-four-gauge needle is as painful as Dr. Kells claims it is, can you imagine how much more painful the puncture must be when a twenty-two-gauge needle is used? I have in many instances watched operators pass a twenty-two-gauge needle into the dense gums and at right angles to the bone until the full depth of the tissue was penetrated. This is an intensely pain-

ful method, and the pain inflicted by such a puncture is so severe in some cases that the patient often draws his head away from the operator, causing the needle to become disengaged from the tissues, and thus necessitating the repetition of a disagreeable procedure under most trying conditions.

There is no reason for subjecting your patient to such discomfort. The much dreaded pain of the needle puncture can be entirely eliminated if you will use a very fine gauge, short bevel needle and insert it only into soft areas.

Use the finest gauge needle that you can procure. A twenty-seven gauge or a twenty-nine gauge, short bevel needle can be inserted into the tissues painlessly.

The point of entry for your needle is in the mucco-buccal fold opposite the apex of the tooth you wish to anesthetize. The anesthetic fluid is to be deposited above the apex of the tooth so as to block off sensation to the tooth and its surrounding soft structures. The shortest distance to the apex of a tooth is at the apex of that tooth. If the lip is grasped between the thumb and the index finger and pulled down and away from the teeth an angle will be formed by the lips and the gums. It is through the apex of this angle that you make your first and only needle puncture. When the lip is pulled down in this manner the mucous membrane lining the mucco-buccal fold becomes taut similar to a piece of rubber dam when stretched and it permits the passage of the fine short beveled needle without inflicting the slightest bit of pain. This is possible because the elastic membrane in this region has a very limited sensibility.

When the needle first penetrates the mucous membrane of the mucco-buccal fold the syringe should be held with a delicate pen-like grip and directed in such a manner as to bisect the angle formed by the lips and the gums, and not at right angles to the alveolar process as some men teach. If a twenty-seven gauge short bevel needle is used the weight of the syringe will be sufficient to carry the needle past the mucous membrane. The needle is inserted into the tissues deep enough only to pass the bevel. After a few drops of the anesthetic have been deposited at this point, the lip may be relaxed and the angle of the syringe changed so that the point of the needle may be advanced to or above the apex of the tooth. One cc of the anesthetic fluid, and many times less, deposited in this region will produce a deep and profound anesthesia.

Only one insertion of the needle is necessary to carry out this procedure, thereby reducing one form of injury. No force is necessary because there are no tissues to offer resistance to the injection of the fluid, thereby reducing another form of injury. You have in no way interfered with the vitality of the dense

gums because you have not injected into those structures. And you have in no way disturbed the circulation to the gums. In other words you have reduced the manipulation of very vital tissues.

It is generally recognized that in all surgical procedure performed upon the body the prognosis of the case is most favorable where there has been little manipulation of the parts involved; that is to say, reducing the manipulation decreases the injury and lessens the post-operative pain.

I feel thoroughly satisfied that novocaine can be administered entirely free from pain; and that in most cases there will be little or no post-operative pain from the use of the drug.

So I want to make a plea for its more extensive use in general dentistry. There are many times when you might prepare a hypersensitive cavity, or cut a difficult bridge abutment, or make your preparation for a porcelain jacket crown, in comfort to your patient and to yourself if you will but take advantage of a most effective means for producing anesthesia.

Local anesthesia has placed a harmless method at the door of every dentist that is of inestimable value, and if applied in an intelligent manner is practically void of danger or complications, and will in nearly every case relieve the patient of all pain accompanying oral surgery and dental operations.

Prevent pain and I know of no easier way to earn the everlasting gratitude of your patients.

Collecting Dental Antiques

Dr. Joseph L. Pease, 1002 Federal Realty Building, Oakland, California, has been collecting dental antiques for over thirty years. He has in his possession about twenty turn-keys that he has listed and cataloged but finds a few types missing. Of cleaners, scalers or pyorrhea instruments he has a great array, some of which were made a hundred years ago.

Dr. Pease is anxious to add to his collection of dental antiques and is also anxious to get books of 1800 to 1850 on dentistry. It is just a pleasant hobby with Dr. Pease and if any of ORAL HYGIENE's readers have any dental books or antique dental instruments that they would like to dispose of, they might get in touch with Dr. Pease at his Oakland, California, address.

"Happy We Are When Our Mouths Are Clean"

SINGING away in Armenian with clear, sweet young voices, the small orphans at the Near East Relief Bird's Nest Orphanage, near Sidon in Syria, put their whole hearts into the rendering of the song that their dentist, Dr. Srabian, has composed for them. "Birdies we are of Sidon's tree," they announce, "With shining teeth set in ivory." They illustrate their words with open countenances.

"With beautiful teeth we freely smile;
Happy we are when our mouths are clean;
Healthy we grow, in the West we stay,
Always looking happy, neat and gay."

This song is a part of Dr. Srabian's effort to dramatize oral hygiene. He has succeeded so well in arousing and maintaining the interest of hundreds of children in the Near East Relief orphanages in the Syrian area that what he has done may well serve as a model to parents and guardians and teachers struggling with the problem of arousing in their charges a feeling of responsibility for clean mouths.

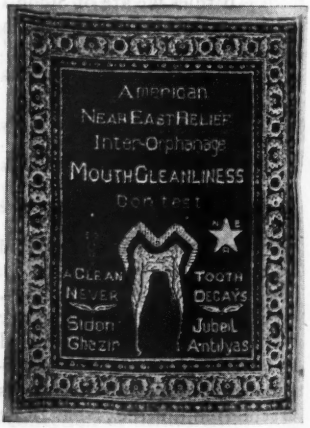
With these younger children at Bird's Nest anything approaching a game holds their attention. They sing wholeheartedly, use soap and water with enthusiasm and substitute for non-existent tooth brushes the determined "finger strong" of their rhyme. The result has been that they have won three times the mouth cleanliness rug-banner that Dr. Srabian has put into competition among the orphanages.

It was their perseverance rather than any competitive spirit that won the prize for them the first time. The other orphanages hardly looked on them as opponents and were profoundly surprised when they found that the banner, designed by Dr. Srabian and made by the orphan girl rug-makers at the Ghazir orphanage, was to stay for six months with the little people. It spurred them on to a more determined effort and at the end of the second competitive period the Hilltop Orphanage tied with Bird's

Each child in this picture is the possessor of "the cleanest mouth in a hundred" at the Near East Relief Hilltop Orphanage, Sidon, Syria. Each is holding the little gift offered by Dr. Srabian as a prize for this success.

Nest. The rug-banner was kept for three months at each place.

Dr. Srabian's knowledge of child psychology told him that with regard to the boys at the Antilyas orphanage arguments about the improvement of their personal appearance were wasted breath. Something else was needed to interest lads of that indifferent age. Crowd enthusiasm could only be aroused by individual enthusiasm. He asked permission to offer small prizes, one to the cleanest mouth of each hundred children. There were six winners and their success meant advantage to every one so every one was stirred to greater interest, for the reward was a handsome Armenian book to be given by the winners to the orphanage library of which all the lads are extremely proud. On the flyleaf was a photograph of young



The rug-banner designed by Dr. Srabian, Near East Relief orphanage dentist, and made by the orphan girl rug-makers at Ghazir, Syria.

donors with their autographs.

To be in a position to make so handsome a gift to the whole orphanage was enviable. Everybody began to "take notice." But it was not until July, 1927, that it was announced that Antilyas had tied Bird's Nest and that the banner would go to each place for three months.

Dr. Srabian's service to the orphans includes not only clinical work but the giving of prizes and talks on mouth cleanliness. Much of his success is due to his personality and his originality in interesting his little patients. His report says: "73% of our children are entirely free from or immune to any oral sepsis." He compares this fine record with 52% which "is said to be the standard of Anglo-Saxon children."

It is these children and other Near East Relief wards in Greece and Armenia who are the first charges against the Golden Rule Sunday donations. Noting the thorough work described in this story and realizing that all the work of Near East Relief is marked by intelligence and efficiency all Golden Rule donors may be assured that any sacrifice they make is well worth while.

The American Stomatological Association

It has been called to the attention of the Executive Committee of the American Stomatological Association, that a new society called "American Society of Stomatologists," is mistaken for the American Stomatological Association on account of the similarity of names. The American Society of Stomatologists has no connection whatever with the American Stomatological Association but has been recently organized by Alfred J. Asgis, D.D.S. Dr. Asgis resigned his membership in the American Stomatological Association last June and since then has had no connection with this society. It is unfortunate that the title of Dr. Asgis' new venture, initiated without the knowledge or approval of the American Stomatological Association, should so closely imitate the name of the old society.

G. Reese Satterlee, M.D., President.

New York, N. Y.

HOW DO WE

By BARTLETT ROBINSON, D.S.,

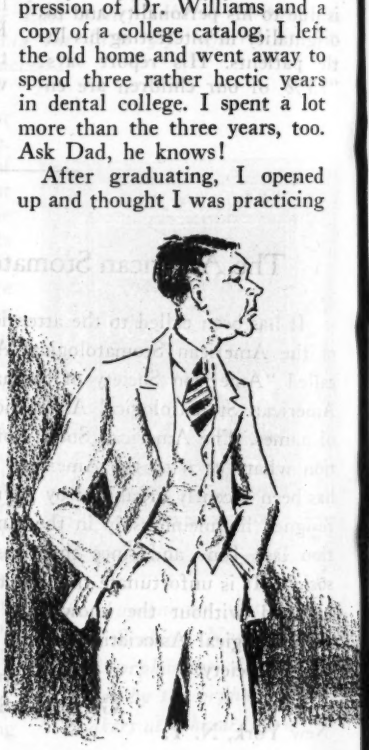
AS I may have said before, it is rather difficult, in writing articles such as this, to refrain from what may seem an immoderate use of the perpendicular pronoun, but when one of us talks about dentistry, each of us knowing that he, and he alone, is probably the very best dentist in the United States, the "I's" and the "me's" are bound to occur with startling frequency.

Every mother's son of us had some darned definite object in view when we paid our matriculation fee and entered dental college. I'll be frank; I did not want to spend the rest of my life clerking in my father's grocery, and I always thought that Doc. Williams, the dentist in our little suburb, led an easy life, and after hearing father and mother discussing his fees once or twice, I decided he was getting wealthy at it, too.

Of course, I did not know at the time that poor old Williams was about as near snow water as he could get without being actually overtaken by starvation, and he, of course, could not be expected to tell my family what he really thought of the profession of which he was a member. But he did tell my dad that he should send me to any college other than the one of which he was an alumnus, and as I have grown older and craftier, I've discovered that in nine cases out of ten, when you hear a dentist knocking the college from which he graduated, there is more apt to be something wrong with the man than with the college.

But to get back to our knitting. On the strength of my impression of Dr. Williams and a copy of a college catalog, I left the old home and went away to spend three rather hectic years in dental college. I spent a lot more than the three years, too. Ask Dad, he knows!

After graduating, I opened up and thought I was practicing



WHO DO IT?

D.S., New York

dentistry. As I may have told in previous articles, I was just keeping about half a leap ahead of the sheriff for quite some time. And when I finally found out that my biggest liability was my own fear of myself, and corrected it so far as I was able, I really began to practice and make a living at it.

After being out in practice long enough to save up for a real vacation, I went home to spend a month with the folks, and like the sailors who spend their shore leave rowing the little boats in Central Park, I drifted in to the village dental office. My old guiding star, Doc. Williams, was gone, and in his old office a classmate of mine had set up and was headed for the same sort of life that had driven his predecessor to the wall.

When we were in school we had all called this lad "Gramma," because he seemed to feel that he was responsible, in a grandmotherly sort of a way, for all the other fellows in the class. He was a good student, and well liked in the infirmary, and now that he was out on his own, he was still a good student of everything except himself and human nature, and after I had watched him work for a while,

He beat her to it by telling her he'd put it in for two fifty.

I saw that he had lost none of the skill he had when in school.

But I was rather surprised to see that much of his work was extractions, amalgams, and pottering little jobs that amounted to nothing, and for which he got very small fees.

I wondered about it, and when I asked him, he said that most of the people could not afford any "regular" dentistry.

That surprised me, as I knew that the neighbors of my own family were all fairly able to get what they wanted, and equally able to pay for it.

I hung around the office quite a lot during the month I was in my old town, and I learned a lot of things about dentists, and why some of them are such poor business men. "Gramma" was about the poorest excuse for a business man I have ever met.

One morning the wife of the hardware merchant came in to have a tooth filled. "Gramma" called me over to the chair to take a look, and I gazed down into one of those mouths that dentists dream of.

Boy, she needed everything. I expected "Gramma" to start in by telling her the shape she had let her mouth get into and abuse her gently for doing so, but that noble soul merely looked at the tooth she said she wanted filled, and rather apologetically told her that a good amalgam filling would cost her three dollars. When she opened her mouth to reply, "Gramma," fearing that she was going to complain about the price, beat her to it by telling her that he would put it in for two-fifty.

After she had left the office, I asked my colleague why he did not talk to her about the general condition of her oral apparatus, and try to get her to let him do some of the work she really needed, but he, poor soul, felt that would not be ethical, and said that she would come in later, as her other teeth needed attention, and that he would get the work anyway.

The poor devil is due for an awful shock when he finds that she spent over a thousand dollars with one of the city dentists for work "Gramma" could have had for the asking.

Once in a while he managed to get a plate case, and when he did, he collected the munificent fee of fifteen dollars. I tried to tell him that he was merely selling dental supplies, and selling them at a smaller profit than the dealer, when he worked for the fees he obtained.

Speaking of plates, an incident occurred one day that really made me think. A salesman for one of the supply houses called on "Gramma," trying to collect an over-ripe bill. "Gramma" argued about some of the items on the statement, like all of us do, and in checking them over, came to a charge for making a plate in the supply house laboratory, amounting to fifteen dollars. Carefully the salesman explained that the plate was made of one of those bakelite materials which seem so popular, and that fifteen dollars was the

charge for making it. "Gramma" was horrified. He had charged only fifteen dollars for the whole case, and the patient had not paid for it yet.

I felt so sorry for the poor chap that I told the salesman that I thought the charge *was* high, as I knew there would only be five or six dollars worth of the stuff in a single denture, and he started telling me about the extra work required to make it. Then he said a most surprising, but a most sensible, logical thing. "If we charge a dentist fifteen dollars for one of these plates, he knows he's bought something, and he will charge his patient accordingly."

I got to thinking that over. "He'll know he's bought something, and he will charge his patient accordingly."

You know, fellows, I've been accused of a lot of things for throwing some bouquets at the dental dealers, but I'm still doing it. They taught me how to earn a living at dentistry, and they are trying to teach the rest of you, and if they make a few dollars in the process, while you make a great many, why should you kick?

Some anonymous bird wrote an article that appeared in the July issue of ORAL HYGIENE.* As long as he wants to stay alive, he'd better stay anonymous, too. If that egg wasn't kidding when he wrote that piece, he's the world's prize boob, nit-wit and moron. He talks about luck. He does not even know what luck is. He's lucky to be alive. The squirrels in his town are either overfed or else there aren't any.

When anybody can show me how I can make fifty dollars, I do not begrudge him five or ten dollars for himself.

In fact I pay my office girl on a percentage basis, and some weeks she makes more than I used to in a month. I've had other practitioners tell me that I'm spoiling things for all the other dentists in my building by paying her so much; they say they cannot afford to pay any such salary as that. I tell them that I could not afford not to.

I have a very good friend who is in the real estate business over in Jersey. Buys a cow field, puts down a sidewalk or two, calls it Earthly Eden, or some such name, and puts his salesmen out selling it as building lots. This man assumed control of the business a few years ago when his father retired.

He works all his salesmen on the regular percentage basis as used by all members of his local realtors' association. A few months ago his father happened to be in the office, and in snooping about, he happened to see some of the commission checks that had been paid the salesmen. He hit the ceiling. No real estate salesman was worth a thousand dollars a month, and all the rest of it. His son had a hard time to keep him from wrecking the office, even after telling him that he was paying the men exactly

*"Broke and Discouraged," page 1293, July, 1927, ORAL HYGIENE.

the same percentage the father had paid, and that when a salesman made a thousand dollars for himself, he made many times that for the company.

That's the story I use on the other dentists when they tell me how foolish I am to pay my secretary what I do.

Why will a dentist spend his time, and his money and his very life trying to practice a profession that is absolutely essential to the people, and then be afraid to even try to get a fair living out of it? Ask me another, I can't answer that.

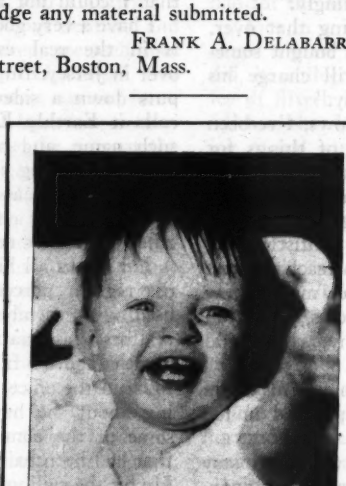
Information Wanted

A committee from the American Association of Dental Schools desire to secure data and information on the subject of Children's Dental Service, to compile tables relative to results obtained.

In addition please state when the clinic was established, under what affiliation, the operative policy and the age limit for admission and dismissal.

The committee is to report on March 29th and will appreciate and acknowledge any material submitted.

FRANK A. DELABARRRE, Chairman.
520 Beacon Street, Boston, Mass.



International Photo.

Little Gertrude Olmstead Newell of Jersey City, New Jersey, is a dental prodigy. She is only one year old but has 16 teeth.

Taking Licenses Away

Dear Editor:

After a careful perusal of your editorial in November '27 ORAL HYGIENE I feel inclined to offer a comment thereon. In the letter you quote, I note that it is "unlawful for an unlicensed person to own a dental office" in California. This premise is false and far fetched, and doesn't have a single leg to stand on in any court other than a Kangaroo one, which by way of explanation is a court consisting of grand jury, petit jury, judge and executioner combined into a single unity. The only law that will stand in a court of record is one directly applicable to the actual performance of dental operations upon the living human body, and the factor of ownership of the office does not legally enter into the proposition at all. A legally licensed dentist can practice in a chop suey joint, using a chop suey sign if he so choose, call himself a "painless dentist," a "royal dentist," his office a "dental parlor" or what not, his equipment can belong to his wife's mother's aunt, and he cannot legally be debarred from practice.

Most towns of any size have a "clinic" and it is so known and called that by the public as well as by the owners, and which in some cases partial ownership may be held by persons who are not licensed dentists or physicians, yet the dental and medical arts are pursued in these institutions in a so-called legal manner, usually by a high-class type of skilled specialists.

No legislative act can prevent what we term advertising dentistry, much as we who style ourselves as ethical may wish it. To be candid, is there much difference between advertising by newspaper and lurid signs and dodgers, than in robing one's self in a "klan" gown and having the operating chair at a highly lighted window, there chiseling bone within plain view of the "yokels of Main street?" Both are done with the same purpose in view.

Courts of Law hold "personal liberty and rights" as sacred, and zealously throw their constitutional safeguards around them. They are not prone to fall into traps of sentimental jealousy and personal

prejudice. Neither does constitutional law swerve from the straight and narrow path where such questions are involved.

Regarding suspension of license for "inefficiency in practice of dentistry." If one is so inefficient why was he licensed and isn't it a confession of "inefficiency" on the part of the license granting body when they attempt to correct their own error? This savors too much of "ex post facto" which is expressly forbidden in Sec. 9, Par. 3 of the Constitution of the United States. The elements of both personal skill and opinion center largely in this proposition and the line of demarcation is so dimly drawn that it becomes dangerous ground upon which to determine justice. One might insert an amalgam restoration. Another might condemn it and insist that a gold inlay was proper. It is simply a matter of personal opinion and to be frank, in most cases the state of the patient's bank account is the predominant and deciding factor. Both materials mentioned will and do save many teeth. The "royal dentist" has a filling material known as "bunkum," insists on using it, shows clinical evidence of failures of both gold and amalgam, and advances the argument that those who use them are "inefficient."

How many operators agree on the root canal problem? Are those inefficient who differ from your pet system? Isn't it a fact that we all have failures in this phase of dentistry? Surely we are not all inefficient. * * * *

Errors of judgment and plain everyday mistakes are part and parcel of all human endeavor and members of state boards are not immune. Each state has its coterie of dental politicians and as to the whole they will assay about 5 per cent. The 5 percenters usually are sincere, capable men of high integrity, but at times may become over-enthusiastic and imbued with Utopian ideas. Their legislative conceptions may be prompted by whim and caprice, no doubt honest in their endeavor to properly protect the public, but apparently blind to the fact that one cannot legislate morals, neither can one legislate any unconstitutional acts and have them stand the acid test of the Appellate Courts.

Some one aptly said, "Republics fall by prosperity, monarchies by poverty." Mussolini holds the center of the political governmental stage today and is flanked by the Russian Soviet principles. What the harvest may be no man can say, but our constitutional government in America seems productive of results that enable us who live under and obey its principles to enjoy the best that the whole world has to offer.

Having been engaged in dentistry for more than a quarter of a century, have seen many "isms" arise, fall, decay and be forgotten. I am not antagonistic to new ideas, but have held rather close to conservatism and feel that we 95 percenters

should give closer personal supervision to the political acts of the 5 percenters, helping them to observe what I term the "silver rule," i. e., live, and let live, pass silently over the faults of our brethren and rectify our own errors insofar as we can.

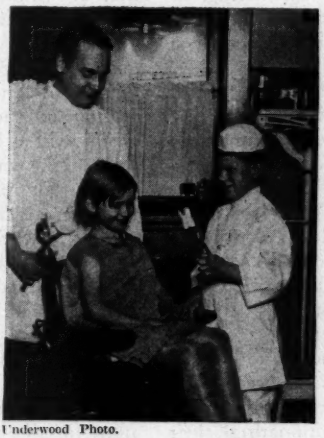
W. G. McGLUMPHY, D.D.S.
Moundsville, W. Va.

Editor ORAL HYGIENE:

I was so interested in Dr. Frank Fitzpatrick's write up of the national meeting at Detroit, that I just want to write and tell you that I think it's the *best write up* I have ever read in all my experience of over 60 years practice in dentistry. So I want to congratulate you and Dr. Fitzpatrick.

Sincerely,
R. B. ADAIR, D.D.S.

Atlanta, Ga.



Underwood Photo.

Cook County, Illinois, children's clinic with staff of eight dentists performed over 200,000 dental operations in the four years since its establishment. Dr. Corvine Stine, Superintendent, with Ruth Reis in chair and Albert Wallner.

On the FENCE

By W. J. HOLROYD, D.D.S., Los Angeles, Cal.

I HAVE been asked by your worthy editor to write an article on "sword fencing" as an aid to the health of dentists. It was a large order, for as a sport, it is very little understood, being a very broad subject, going back into the ages, and in order to have the reader comprehend the status of the sport, as now practiced, it is best to deal with it more in the form of a narrative, which I will endeavor to make interesting, as well as instructive.

It will be well to outline a brief history.

Every man and woman with an ounce of red blood in their veins have in their lifetime been thrilled with the vivid accounts of hand to hand combats, as described in the Waverly Novels, Tales of the Seas, Gentlemen of France, Conrad's stories, etc., and various books on the conquests of nations.

Mediæval heroes had to be masters of fencing, otherwise they would have been eliminated long before the book ended, thus eliminating their chances of marrying the heroine, much to the disgust of the reader.

The art and science of fencing goes far back, and the geometry, timing, and mechanics, call for deep study, in order to become expert at the sport.

Fencing, as practiced today, is naturally like any other sport, an evolution of what has gone before, and today, though not generally known, there are better fencers than ever before.

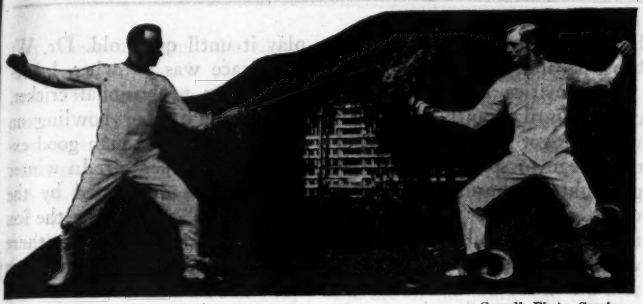
Like other things in the last fifty years, there has been a compiling, a stock taking, a casting out of things that are not good, and an introduction of ideas that are sound, an interchange of ideas, of different schools, an adding to of perfectly obvious good ideas, a co-operation of the masters of fence, and an organization of the sport that has never existed before in the history of the world.

All this results in the best that there is in the art of fence coming to the top.

Fencing is hard to learn, being considered the "chess" of sports, as well as one of the major sports, and more and more devotees are coming into its ranks than ever before.

It will never be widely popular, for the simple reason that it is difficult to master. Anything that is popular must of necessity be easy.

Again, temperament enters into the adaptability to a great extent.



—Carroll Photo Service

The analysis of this phase is most interesting. Only people with a mental motive temperament become swordsmen. The phlegmatic type may as well stay out of this sport. The slow mover would get touched so many times that neither himself nor his opponent would get any pleasure out of a bout.

Some people get their pleasure from sports that deal with inanimate things, such as horizontal and parallel bars, rings, dummy horse (or buck), shot putting, billiards, pole vaulting, cards, golf, etc., etc., and, as the good professor said, "The troubles and perversities of inanimate objects are manifold."

Another type of person like their sports with the human element in them, such as wrestling, boxing, fencing, football and the like. In order to get their greatest thrill out of sports, they require the combative physical contact, coupled with a contest of wits. This latter type of sports are mostly enjoyed by the descendants of the Anglo-Saxon races.

Fencing is an exceedingly "fast" sport—seconds are split into fractions—a touch coming so fast that the onlooker can hardly see it—making the judging in this work a very difficult accomplishment.

This element of combat, this thrill of fighting is one of the most fascinating phases. The matching of brawn and brain, the intense tension and alertness required, make the blood, brain and muscle work at top-notch efficiency. Shakespeare says, "A man lives more in a bout of fence than some others do in a lifetime."

To the busy man of mental motive type who leans toward these latter sports—it is particularly fitted. The curious exhilaration and keenness of the brain after fencing has often been spoken about and noted.

Many dentists are so situated that they cannot afford the time or money to play golf. We all know what dentists should do and they know it too. But circumstances have been too much for some men, and they are working hard in the hopes that some day, somehow, they will

be like their more fortunate brothers and get afternoons off.

In America it has been the custom until recently for a man when he got out of high school or college to stop athletics and get right into business. Athletics were considered a "waste of time." The result was—if he was naturally healthy he "carried on" until about 40 years of age and then he began to "crack." His physician ordered a new regime, careful diet and more exercise—easier said than done. By this time his abdomen was generally distended, he was over-weight, his muscles were flabby. The cartilages between his joints are soft and could not stand any impact — therefore, sports, like baseball could not be indulged in, because the starts and stops are too sudden, the exertion is not gradual enough—sliding to base can not be thought of, as a snapping of an ankle might result therefrom.

Wrestling after many years of absence—is not so good. And boxing, for a dentist with the possibility of black eyes and bruised hands is not practical at this stage of life.

Upon analysis, there have not been developed in America, as yet, any "slow" sports in which older men may indulge, except golf.

For instance, in Europe, soccer football called "association" is indulged in by mature men, as there is a chance from time to time to rest, and let the other members of the team play the game. Cricket is good and men play it until quite old. Dr. W. G. Grace was 67 when he retired from professional cricket. Green bowling or bowling on the green, gives a man good exercise in the open air. In winter this sport is duplicated by the Scotsman's "curling" on the ice.

If you pause to think, there are not many safe sports in America that a man can work at after 30 years of age and get up a good perspiration. Remember Muldoon, the famous wrester, says that a man should sweat from the inside out at least one a day—that is strengthening—as differing from the "cabinet sweat" of the Turkish bath which is weakening.

Setting up exercises, such as Walter Camp devised are never popular very long. Exercise to be popular is better when incorporated in games that are safe and yet quick enough to insure a profound perspiration. These factors are hard to get where they fit older men.

Fencing incorporates the above. The new designs of masks, gloves and jackets reduce to a minimum any likelihood of injury.

Sports that are somewhat in between the aforementioned are squash, handball, swimming, running, tennis — embodying many favorable factors, but not to the nth degree that is applicable in fencing.

In the ages gone by, there were many forms of swords for single combat and methods of using them.

For instance, in the 16th cen-

tury, there appeared the single stick, a round stick of ash or hazel 34″ long with a basket to protect the hand. This, in a way, was the forerunner of the Sabre play as used today. They had no head masks at that time and one can imagine how they whacked one another so that they were black and blue for days after. It was a case of "lay on McDuff and damned be he who first cries 'hold, enough.'"

About 100 years later, to show how things "evolute," the original form turned into a wooden sword or back sword, originally with a heavy metal guard which again was replaced by a wicker guard.

The guards, cuts and parries of single stick, were identical with "back sword play"—no thrusts being allowed.

The old idea in the 16th century was that hits below the girdle were unfair. These rules disappeared in the 18th century and all parts of the person were attacked. Under George I and II this pastime was immensely popular, only being rivaled by wrestling.

A little later the play began to "tighten" up. (18th century.) They placed the players closer together, feet were still and all strokes being delivered with a whip-like action of the wrist from a high hanging guard, the hand being held above the head. (This I presume was where the present "duelling" now prevalent at Heidelberg, known as Schlager Fencing originated, but today is not considered practical by the French and Italian school.)

Blows on any part of the body above the waist were allowed. Bouts were *decided only* by a "broken head" *Q.E.D.* During the last quarter of the 19th century, single sticking practically died out, but was revived as a school for the sabre; the use of the point and leg hits were allowed.

At the beginning of the 20th century, the introduction of the light Italian fencing sabre rendering the single stick less necessary.

French cane fencing has a good deal in common with single stick play, but is designed more for defense than offense.

Another interesting phase of sword play is this: that the light, quick short man has a chance against the heavier, slower moving opponent. The heavy man naturally turns to force, but in no other game where physical contact is concerned, can two opponents of widely different physiques get so much fun together out of an exercise.

As the best swordmanship came out of Italy, naturally the next nearest country was France, and on to Spain. Now, the physical characteristics of the men of these countries are somewhat similar inasmuch as they personify the hit-and-get-away method of fighting in contradistinction to the more northern countries where slashing and force were the custom.

(Continued in Next Issue)

"Ask ORA

SOME time ago you recommended to me sedative cement for exposed pulps. I wish to thank you for the suggestion for in many cases the results were very satisfactory.

In several cases the pulp will be quiet for a month or more and then hurt considerably for an hour and pass off. In a few cases the teeth are very sensitive to heat or cold. In these cases do you advise me to devitalize?—Louis Levin, D.D.S., Philadelphia, Pa.

Reply—I would suggest that you read very carefully Dr. George R. Warner's article on "Pulp Conservation" in the May *Items of Interest*. He explains very comprehensibly the difference in the types of cases, describing and classifying quite lucidly those cases most favorable for pulp capping and those less favorable or unfavorable.

Without the opportunity to study and consider individually the particular cases that you refer to, I can only answer your questions in quite a general way. In the first place I wonder if you are making absolutely certain to remove every vestige of decay from proximity to the pulp before placing the sedative cement as a capping. This is important. It is decidedly better to excise a portion of the pulp along with the decayed dentine than to leave any decay whatsoever in the cavity. I really do not understand the teeth being abnormally sensitive to heat and cold after capping with this material unless you used too small an amount for your capping, thus permitting the metal of the final filling to come too close to the pulp, as this sedative cement is one of the very most effective non-conductors of thermal change known to the dental profession.

If you have a case that becomes acutely sensitive to heat and where the pain is quickly relieved by the application of cold, you then undoubtedly have a pulp that is in a disintegrating or dying condition, and prompt devitalization is the wisest course. But a case that is sensitive to cold is, I believe, invariably a healthy pulp and I should encourage the patient to have patience, telling him that this condition will probably subside, which it usually will as the pulp protects itself by the laying down of a layer of secondary dentine. But if it is too much of an annoyance to the patient, I should then remove the filling and place as thick a covering of sedative cement upon the pulp as the particular cavity will permit, still allowing sufficient anchorage for the retention of the final filling; in fact, I think I should fill the entire cavity with sedative cement and allow it to remain so for several weeks, at which time I think you will find all abnormal sensitiveness completely subsided.—V.C.S.

The patient, a lady 40 years of age, quite a few years ago

RAIYGIENE"

Conducted by V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Bldg., Denver, Colo.

Those having questions to ask or answers to submit to questions already asked, or other comments to contribute, will kindly communicate directly with the above named Department Editors. Please enclose postage when personal reply is desired.

lost the two lower first molars, and one upper first molar. This has resulted in a shifting of position of most of the other teeth. The patient claims that originally her bite was normal, but now you can see that there is a protrusion of the lower arch with the lower anteriors biting outside the upper anteriors. The four upper anteriors (centrals and laterals) have worn down and chipped off considerably as a result of this change, until they are now quite short and in need of some form of restoration. If porcelain jacket crowns are put on it seems to me that it will necessitate a raising of the bite. I would like to have your opinion as to whether it would be advisable and possible to do this satisfactorily. If so, do you think that it would be also possible to change the relation of the two jaws so that it could be brought back to normal again, with the lowers biting inside the upper anterior teeth. I will appreciate any advice you may be able to furnish me with.—Wendell A. Gray, D.D.S., Coral Gables, Fla.

Reply—Your case is unquestionably one of bite-raising. I seriously question the inter-maxillary relation ever having been normal. The condition has probably grown worse due to the loss of the molar teeth. In my opinion the treatment of this case would necessarily include raising the bite, bridging the spaces in the mandible and putting porcelain jackets on the four incisors and probably right cuspid. This would not establish a normal inter-maxillary relationship but would enable you to make an end to end bite with a very good appearance resulting.

We recently treated a similar case in which we did nothing but raise the bite. Raising the bite tends to retrude the mandible and in the case of which I speak the maxillary incisors were not chipped and not badly worn. Raising the bite changed the profile markedly, giving a reasonably normal appearance.

I believe your case would work out the same way, except that the raggedness of the incisors and shortness of the right cuspid necessitates the use of porcelain jackets.—G.R.W.

Am sending a model to you on which I have marked teeth to be extracted on account of

abscesses. How would you go about it to repair this mouth with a removable bridge?

Would a fixed bridge be practical in this case?—H. C. McGinnis, D.D.S., Yuma, Colo.

Reply—I have marked with lead pencil on your cast what I think would be a practical outline for a removable denture to supply these teeth that you have marked for extraction.

In this type of a case, with first molar, both bicuspids and cuspid missing on one side, I believe that a fixed bridge is really not indicated, though it would be possible to construct one that would serve for a number of years by including four teeth as abutments, splinting the second and third molars and attaching to the lateral as a pier and the right centrals as an abutment, supplying the left central which you have marked for extraction.

I really believe, though, in a removable, such as I have outlined on the cast, with a supported type anchorage on the first molar on the left side, with a clasp without the occlusal rest for the right upper second molar adjoining the three teeth that are to be extracted. The extracted molar, bicuspids and cuspid can then be supplied on a vulcanite saddle and the lone central should be a facing, cemented or soldered directly to the gold bar and backing. I believe that this case can be perfectly made as an Akers type one-piece gold casting, with the exception of the molar, bicuspids, and cuspid which should be supported with vulcanite. This could be replaced with a gold saddle after the process has sufficiently absorbed. —V.C.S.

This one got me going! Patient, woman about 50 years. Lower right region of wisdom tooth, gum inflamed once in a while. X-ray shows "spot." I have taken other pictures, a second mesiodistal also enclosed, shows same thing. What is it? Thanks very much for recent information, everything turned out fine.—M. Kaplan, D.D.S., Jersey City, N. J.

Reply—Neither of these x-ray films are as clear as they should be, but that white spot is unquestionably a speck of metal, probably a chip of amalgam that has lodged in the socket at the time a tooth was extracted in this location. It does not, however, look as though it could be the cause of discomfort, as no particular area is apparent directly around it, and it seems to be completely embedded in normal healthy bone. In the darker film it looks to me as though there were an area of rarefaction just above the amalgam and directly under the crest of the ridge. I think it would be well for you to lance the gum over this area and lay the soft tissue back and explore for a granulomatis or necrotic area.—V.C.S.

I am sending to you today plaster models. This young lady is 16 years of age. Would you advise extraction of upper centrals and laterals and bridgework from cuspid to cuspid for quick method or extraction of upper bicuspid on each side and orthodontia appliance to force the anterior teeth back? Enc. postage for return of models.—J. J. Tomiska, D.D.S., Grand Island, Nebr.

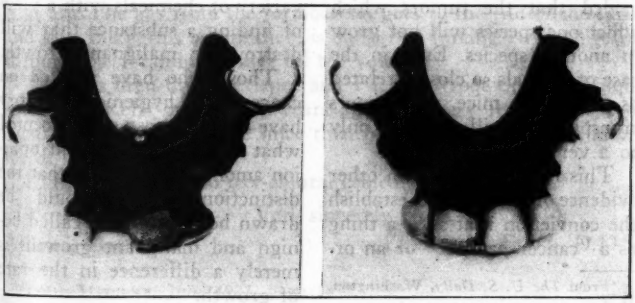
Reply—Would say that the case presented is one of second class Angle Classification or disto-occlusal, i. e., the lower jaw is from 1/8 to 1/4 of an inch distal of its normal relation to the upper jaw, therefore extracting the maxillary incisors and putting in a bridge would not overcome the difficulty at all, no more than would extracting the bicuspids and retracting the upper teeth. The only way to correct the malocclusion is by changing the relation of the jaws and accompanying this change of relation by change of the contour of the maxilla. In this way the young lady's occlusion could be improved, as well as her facial contour.—G.R.W.

POLICE DEPARTMENT
CITY OF NEW YORK

January 5, 1928

The Detective Division of the New York City Police is desirous of establishing the identity of a white woman—found dead in a hotel in that city December 21st—who had an upper partial rubber denture, four fronts with right central and lateral gold dummies molar clasp on right side and second bicuspid clasp on left side containing one artificial porcelain central and lateral.

The woman was between 25 and 30 years of age, 5 feet, 3 inches; weight 107 pounds; grayish green eyes; black bobbed hair, abundant; black eyebrows.



Cancer*

By PROF. CARL VOEGLIN
Chief, Division of Pharmacology, Hygienic Laboratory, Bureau of the Public Health Service

A STUDY of cancer in its broad aspects is another of the problems now before the Division of Pharmacology. This investigation proceeds on the theory that cancer is an abnormal tissue growth. On this hypothesis the Division has been experimenting with the growth of tissue from the heart muscle of an embryo chicken outside the body on the theory that when the processes of normal cellular growth are understood it may aid in an understanding of abnormal growths.

Another phase of this work has been the successful transplanting of animal tumors from one animal to another which revealed that the tumors which afflict one species will not grow in another species. Even in the case of animals so closely related as rats and mice the tumors transplanted will develop only to a very limited extent.

This fact together with other evidence has tended to establish the conviction that such a thing as a "cancer parasite" or an organism which specifically causes cancer does not exist.

Some of the causes of cancer have been indicated by experiments on animals; notably the demonstration that painting the skin of rabbits or mice with coal tar for long periods will produce growths which are, apparently, real carcinoma.

It has also been shown that the presence of certain parasitic worms will produce cancerous growths in rats, and there is evidence, although it is not conclusive, that a continued application of arsenic to the skin will produce the same results. Animals bearing tumors are subjected to treatment with a great variety of chemicals with a view of finding a substance that will destroy the malignant growth.

Those who have worked on cancer in the hygienic laboratory have for the most part accepted what is now the prevalent opinion among investigators that the distinction which should be drawn between the so-called benign and malignant growths is merely a difference in the rate of growth.

*From *The U. S. Daily*, Washington, D. C.

Still another phase of the cancer research work for the division is a study of the chemistry of normal tissue and a comparison of the data thus gained with corresponding data obtained from a study of the chemistry of cancerous tissue. Some evidence has been found to indicate a difference in the sugar metabolism but nothing definite has been established.

In addition to the activities heretofore enumerated the Division of Pharmacology is also engaged in a piece of research so fundamental in character that it can hardly be explained in non-technical language. That is a study of the toxic action of various drugs upon living cells. At present the crude results of these actions are known in many instances but the more intimate chemical nature of the actions is not known. It is a problem that involves the very fundamentals of pharmacology and toxicology.

The normal staff of the Division of Pharmacology consists of eight scientific workers besides clerical assistants and attendants. Additional information concerning the work of the division may be obtained upon application to The Surgeon General of the United States Public Health Services.

Editor ORAL HYGIENE:

I have just read in ORAL HYGIENE the letter from James E. to Dr. Kells.*

If James had only opened the tooth he wrote about and merely opened the pulp chamber without entering the root canal at all and saturated a small piece of absorbent cotton with the formocresol, placed it in the pulp chamber, sealed it in with temporary stopping and left the tooth alone for two or three days, not longer, then proceeded to clean and disinfect the canal and fill it, the chances are 95 to 100 his patient would have had very little pain afterward, if at all. The gas from the formocresol goes to the end of the canal and kills the germs before there is danger of forcing virulent germs through the foramin to stave off the volcons.

This has been my experience and I learned root canal technique from Dr. Kells over thirty years ago, and very few of the root canal fillings I have made since then have given any trouble afterward.

I fill the canals with oxy-chloral cement.

Very sincerely yours,

Atlanta, Ga. FRANK H. FIELD, D.D.S.

*ORAL HYGIENE, June 1927, page 1092.

International Oral Hygiene

Translated and briefed by CHAS. W. BARTON

FRANCE

Dr. G. Variot, of the children's hospital at Belleville, reopens in all seriousness the question of a definite correlation between the first dentition and certain systemic disorders prevalent during this period in most infants. The author has made a particular study of the effect of growth and increase in weight on dentition, and vice versa, and has come to the positive conviction that statural and ponderal growth are closely interrelated with the process of dentition. He holds that the opinions of Guersent hold good today in spite of their rejection by Magitot, Politzer, and others. In fact, instead of having been definitely discarded to the realm of the ridiculous, the problems of the influence of dentition on the systemic conditions of infants should be studied anew and very thoroughly, with a view to determining both cause and effect of the evidently sympathetic symptoms occurring in other organs during the eruption of the deciduous teeth. It is the author's opinion that the frequent troubles in the digestive and respiratory tracts, the nervous system, the skin, the salivary glands, etc., of the baby are aggravated by temporary derangement of nutrition and ponderal and statural growth. *La Revue de Stomatologie.*

CUBA

The "Centro de Dependientes del Comercio" of Habana has installed in their association building a suite of dental offices for the benefit of its members. Four dentists are functioning in this dental clinic which, judging by photographs received, is equipped with the most modern and first class equipment.

* * *

In a study on the relationship between nasal affections and dental lesions Dr. Jose D. Echemendia relates some of the many cases in which acute and chronic affections of the nasal mucosa have been caused by diseased teeth. This is the more interesting, since in all the cases seen by the author the dental lesions were the unique cause for the pathological conditions in the nose. It is especially the upper laterals and the cuspids which give rise most frequently to complications in the nasal passages. Apical abscesses and alveolar necrosis are mostly responsible. In most of these cases the nasal affections have a more or less spasmodic character, but in cases of long standing there may be found veritable inflammatory and hypertrophic processes. *Cuba Odontologica.*

GERMANY

Dr. K. L. Koneffke, of Dresden, has made an extensive study of the responsibility which has been ascribed to toothbrushes and toothpowders in the causation of erosive defects of the teeth. He has come to the conclusion that the toothbrush itself never causes erosion of the hard tissues of the teeth, but that crystalline admixtures to the powders employed in the manufacture of dentifrices are liable to produce cuneiform and other erosions on the tooth surfaces. Dr. Koneffke having studied the abrasive most generally used in the making of powders and pastes, i. e. calcium carbonate, deems the so-called precipitated chalk as unfit for dental use, and recommends the exclusive use of chalk separated by air-sifting, which will produce a powder that appears free from crystals and admixtures under a magnification of 2,000 dia. *Odontologische Revue,* Prag.

* * *

In a survey of the diseases of the deciduous teeth Dr. Hans-Hermann Rebel, of Gottingen, warns against the unnecessary cleaning of a baby's mouth before the eruption of the first tooth. No such cleaning is required as long as the mouth is not diseased. Any attempt at a chemical or mechanical cleansing is dangerous on account of irritation and laceration of the mucosa whose epithelium is thin and tender. The aphthous stomatitis of Bednar is nothing but erosions of the mucous membranes caused by unnecessary cleansing.

After the eruption of the teeth oral prophylaxis should be instituted by and by, and taking into consideration the sensitiveness of the tissues. Gargling and rinsing are just as important as brushing and scrubbing. *Diagnostische und therapeutische Irrtumer,* No. 2.

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BRITISH WEST AFRICA

According ot a letter from Mr. W. Addison to *The Times* there is a dearth of dentists in this British colony on the dark continent. Mr. Addison knows of no qualified dentists of African birth practicing in British West Africa, and the energies of the one or two British dentists practicing there are concentrated on the coast towns. What of the twenty-two and a half millions in the hinterland? *Dental Record.*

* * *

ITALY

The first free dental clinic for school children at the Hospital "Regina Elena," the opening of which was reported at the time in ORAL HYGIENE, has completed the treatment of 298 pupils of the first grade of the Trieste public schools between April and July, 1925. 834 temporary teeth and 107 permanent teeth were extracted, 184 temporary and 412 permanent fillings were laid. The clinic is open but two hours per day, and with the limited means at the disposal of its dentist, Dr. Ramiro Cozzi, everything humanly possible has been done, although the achievement appears insignificant. School dental clinics are a vital necessity particularly in Trieste with its sad record of tuberculosis, but the means put aside for such dental services is negligible. *La Stomatologia.*

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BRAZIL

In Victoria there has been inaugurated a dental school clinic. The direction of the dental service is in the hands of Dr. Costa Gama who has studied the organization of this service in Rio. After the states of Rio, S. Paulo, and Pernambuco it is in Espirito Santo that school dental service is being organized. *Revista Odontologica Brasileira.*

* * *

The first children's dental clinic has been opened in Rio Claro (Minas) in the schools "Cel. Manoel Pinto." The school "Araujo Porto" in Estrada Velha da Tijuca has also been endowed with a dental clinic, and another one has been opened in Oliveira (Minas). *Brasil Adontologico.*

What's the Matter with the A. D. A.?

By C. EDMUND KELLS, D.D.S., New Orleans, La.

PART II

THERE always have been or at least there have been for fifty years or more—in these United States, a certain few dentists who have served "the cause" long and well, have national reputations, and yet for reasons, which are not apparent, their services never have been adequately acknowledged by the profession in any way.

Such being the case, here I come with a suggestion which would give some of these men an honor which they might well deserve.

I would have our Association provided with an honorary president. Every year, then, one of such distinguished men could be elected to this office.

One might say that if he should be honored, why not make him president and be done with it.

Perfectly good question. Now here's my answer: The president of our Association should be, first of all, a man of administrative ability.

Many a perfectly good honorary president would make a sorry president from the point of administrative ability. The A.D.A. is a mighty big concern, and it needs a man of good business ability and a man with a certain experience in the management of dental societies, to make a good president. Don't you think so?

Then again, the president should be a man of means—that is, as dentists go—because I can well imagine that to be a good president is a terrible drain on one's finances.

I don't mean that the president has to spend so much of his own money in traveling around and visiting the state societies, and attending functions of all kinds, but what I do mean is this: While our worthy president is galavanting around the country upon *our business,*

he is letting his *own business,* his own practice, go to the dogs, and if he isn't a man of comparative means, as I just said, after being the president for one full year, he'd come mighty near being a financial wreck.

Therefore it is that here and there we might find a man whom we would like to have for president, yet we would not like to elect him president because he just happens *not* to have the necessary administrative ability, and again, because he really could not afford to give the time to the "job."

Possibly the distinction should be given our honorary president of making it his duty to *open* the meeting every year; to make a "few remarks," say on a *time limit of five minutes,* when he would introduce the president, and his function would cease.

He might be shown some special attention during the meeting. Possibly it might be nice to present him with a neatly engrossed scroll, noting his election to the office.

As for these details, I leave them to those who can work them out better than I can. I have merely offered these suggestions tentatively. The post of honorary president is what I want to see established; the rest can be left to the members of the Association.

"What's the Matter With the A.D.A.?" you ask? Well, it needs an honorary president, Mr. Editor, and that's what's the matter with the A.D.A.

So now, dear Mr. Editor, I hope you agree with me about this honorary presidency, and will urge the "powers that be" to carry out this suggestion.

One more installment coming.

Who?

Who plants our teeth? That's what I want to know!
Who is responsible for the way they grow?
Who plants the even ones that look like strings of pearls?
Who plants the ugly ones, alike in boys and girls?
Who plants the roots away down deep?
Who makes them crunch and grate when we're asleep?
Who impacts our teeth, curling all the roots?
Who makes them ache and ache down to our boots?
Who makes the cavities small and big?
Who makes the nerves there jump a fine jig?
Who causes Pyorrhea, Halitosis, etc.?
Vincent's Angina, a good variety?
Who causes all the ills man's mouth is heir to?
It must be the Devil, he's the only one who'd dare to!

HELEN J. THOMPSON LANE.

EDITORIALS

REA PROCTOR McGEE, D.D.S., M.D., Editor

Manuscripts and letters to the Editor should be addressed to him at 514 Hollywood Security Bldg., Los Angeles, California. All business correspondence and routine editorial correspondence should be addressed to the Publication Office of Oral Hygiene, Pittsburgh, Penna.

In California

A RESOLUTION passed by the California State Dental Association in its attempt to curb tyrannical actions of the California State Board of Dental Examiners as constituted in October, 1927:

WHEREAS, WE, the members of the Executive Council of the California State Dental Association made up of representatives from all counties north of Santa Barbara County, have repeatedly had our attention called to certain irregularities pertaining to the present State Board of Dental Examiners which have brought about a condition in the dental profession of this State which tends to destroy the confidence of the public in the dental profession and encourage litigation, which is inimical to both the interests of the public and the dental profession, and which tends to destroy the confidence and support of the members of the dental profession of this State in the State Board of Dental Examiners, which, we believe, must end in breaking down the high standards heretofore maintained,

THEREFORE, BE IT RESOLVED, That the Executive Council of the California State Dental